Our mission:
To inspire hope and enhance life for those affected by breast cancer through early detection, advocacy, education and support services

BREAST CANCER ASSISTANCE APPLICATION

APPLICANT INFORMATION		
Name:		
Date of birth:	Email:	Phone:
Current address:		
City:	State:	ZIP Code:
Diagnosis and Date of Onset:		
Tell us where you are in your treatment- past/present and anticipated date of completion:		
Physician:		Phone:
Referral source		
Contact email/phone for the person who referred you to program:		
How did you hear about this program? (internet, krewe website, rack card, physician, friend, other)		
SIGNATURE		
Signature of applicant:		Date:

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HOUSEHOLD INFORMATION
Marital Status:
Please list any members of your household who are dependent upon your support:
INSURANCE INFORMATION
Insurance- (please also list monthly premium):
Monthly premium:
Deductible and MAXIMUM out of pocket:
Co-pays and or co-insurance:
Does the applicant or anyone in the household receive Medicare or Medicaid? (If you do not have insurance have you applied for Medicaid?)
EXPENSES AND INCOME
Please list MONTHLY household expenses:
Housing/Food:
Utilities (to include power, water, garbage):
Car payments:
Other expenses not listed here:
TOTAL monthly household expenses:
Please list the following sources of MONTHLY household income:
Salary:
Social Security (S.S.I.)/Social Security Disability (S.S.D.I.)
Alimony or child support**
Veteran's Benefits:
Unemployment (if applicable):
TOTAL Sources of monthly income: $
******The Breast Cancer Assistance Program is a program of last resort. Please tell us about any other agencies that you have received assistance from or have been denied/turned away for lack of funding:**

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PROPOSED USE OF FUNDING	
Please be specific: We are only able to provide funding for documented expenses and require receipts/EOB's for our records.	
Appointments/treatments :	
Tests/procedures:	
Medications:	
Bras/wigs/turbans:	
Housecleaning:	
Transportation to and from appointments/treatments:	
Family crisis intervention:	
Any other expenses not listed above:	
Amount Requested:	
SIGNATURES	
Signature of applicant:	Date:

*** Please note- By signing this form, the applicant gives The Keeping Abreast Foundation Breast Cancer Assistance Program permission to contact the above physician to verify diagnosis, medical necessity and current/outstanding medical bills as governed by HIPAA law.

Requests for funding are not guaranteed and will be reviewed and met as funds are available and approved.

The Keeping Abreast Foundation Breast Cancer Assistance Program

HIPAA Privacy Authorization Form

** Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R.
Parts 160 and 164) **

Authorization

I authorize _____(healthcare provider)
to use and disclose the protected health information described below to The Keeping Abreast Foundation Breast Cancer Assistance Program.

Effective Period
This authorization for release of information covers the period of healthcare
from:

_____ to _____.
OR

□ all past, present, and future periods.

Extent of Authorization

□ I authorize the verification of medical diagnosis
AND/OR
□ verification of current/outstanding medical bills

□ other

This medical information may be used by the person I authorize to receive
this information for verification of medical diagnosis, current and outstanding medical bills or other purposes as I may direct.

This authorization shall be in force and effect until

_____ (date or event), at which time this authorization expires.

I understand that I have the right to revoke this authorization, in writing,
at any time. I understand that a revocation is not effective to the extent that any
person or entity has already acted in reliance on my authorization or if my
authorization was obtained as a condition of verification of my medical diagnosis and/or medical bills.

I understand that information used or disclosed pursuant to this
authorization may be disclosed by the recipient and may no longer be protected by
federal or state law.

_____
Signature of patient or personal representative

_____
Printed name of patient or personal representative and his or her relationship to patient

Date:

Please mail completed form to:
The Keeping Abreast Foundation Breast Cancer Assistance Program
Po Box 10812
Pensacola, Florida 32504
thekabfoundation@gmail.com